Advance Directive for Mental Health Treatment

Maryland Department of Health and Mental Hygiene



Mental Hygiene Administration

Martin O'Malley, Governor Anthony G. Brown, Lt. *Governor* John M. Colmers, *Secretary*, DHMH

NOTICE: This is an important legal document. Before signing this document, you should know these important facts.

Introduction

Maryland law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. However, a parent or guardian of a person under the age of 18 years may authorize treatment, even over the objection of the minor. The law also notes that at times, some persons are unable to make treatment decisions. Maryland law states that you have the right to make decisions in advance, including mental health treatment decisions, through a process called advance directive. An advance directive can be used to state your treatment choice or can be used to name a health care agent, that is someone that will make health care decisions for you.

- A. If you are a person with a mental illness, this document provides you the chance to take part in a major way in your mental health care decisions when you are not able to. This document allows you to express your consent or refusal to medications for your mental illness and other health care decisions, including use of seclusion and restraints. Please know that Maryland law allows a health care provider to override your refusal for medication for a mental disorder in limited situations if you are involuntarily committed to a psychiatric hospital.
- B. This document may be completed by any individual 18 years of age and has not been determined to be not capable of making an informed decision. An advance directive may be oral or written. If written, it must be signed and dated. Two witnesses must also sign the document. The health care agent may not be a witness. And, at least one witness may not be a person who is knowingly entitled to benefit by your death, for example inherit money, insurance benefits. The witnesses must sign the document stating that the person making the directive is personally known them and appears to be of sound mind.
- C. If you wish to guide your health care providers on what treatment you wish to have if you should become unable to give consent, and you DO NOT WANT A HEALTH AGENT, fill out the form titled "Advance Directive for Mental Health Treatment". If you want an agent to make the choice for you, fill out the form "Appointment of Health Care Agent." You may fill both forms if you want an agent to make the choices and you also want to assist in those choices. If the directive is made orally, it must be made in the company of your attention physician and one witness.

- D. You can also make an advance directive naming a person as your health care agent, to make mental health decisions when you are not able to do so. The agent must make choices in line with any desires you have expressed in this document, or if your wishes are not expressed and are not known by the agent, the agent must act in good faith in what he/she believes to be in the best interest for you. It is your job to inform the agent that the agent has been named in your advance directive, and to make sure he/she agrees to be your agent. It is important that your health care agent be informed about your mental illness and the decisions you have made in this form. It is highly recommended that you discuss the contents of this form with your family and close friends and your mental health providers.
- E. The Office of the Attorney General has issued an opinion that a healthcare agent may sign an individual into a facility, including a psychiatric hospital. If you wish your healthcare agent to be able to make this choice, you should so specify.
- F. Maryland law allows giving a medication for the treatment of a mental disorder over the person's expressed wishes, or placing a person in seclusion or restraints against the person's the person's expressed wishes, under certain conditions.

Advance Directive for Mental Health Treatment

being an adult, and emotionally and mentally able to make this directive, willfully and freely complete this health care advance directive to be followed if it determined by two physicians that I am not able as a result of a psychiatric or physical illness to assist in my health care treatment. (The second physician may not be involved in my treatment). It is my intent that care will be carried out despite my inability to make choices on my own behalf. In the event that a guardian or other decision-maker is chosen by a court to make health care choices for me, I intend this document to take priority over all other means of discovering intent while able.			
The usual symptoms of my identified mental disorder may be include:			
I direct my health care providers to follow my cho	pices as set forth below:		
Medications for treatment of my n	nental illness:		
If I become unable to make informed choices for treatment of my mental illness, my wishes regarding medications are as follows:			
I may be allergic to the following medications: Medication Reaction			

prescribed:	
Initial all that apply:	
I agree to the performar mental health.	nce of all tests and other means to identify or assess my
	nce of all tests and other means to check how well the g and their effect on my body, i.e. blood tests.
I specifically do not agr own brand-name, trade	ree with dispensing the following medications, or their name or generic equal.
Medication	Reasons for not agreeing
I agree with dispensing unless listed above.	all medications prescribed by my treating psychiatrist,
unless listed above. Admission to and continuo	ation of Mental Health Services from a facilit
unless listed above. Admission to and continue other than an inpatient ho	ation of Mental Health Services from a facilit
unless listed above. Admission to and continue other than an inpatient ho Check one I do not have a preference	ation of Mental Health Services from a facilit
unless listed above. Admission to and continue other than an inpatient ho Check one I do not have a preference facility or other provider treatment.	ation of Mental Health Services from a facility of spital. The about receiving mental health services from a

Othe	rs Choices
	n unable to make informed decisions about my mental health choices, my wishes ling other information or options are listed below:
Relea	ase of Records
I auth	orize the release of (check one):
	any and all mental health records
	the following mental health record/ records of the following providers:

Appointment of Health Care Agent

I select the following person as my agent to make health care choices for me:		
Name		
Address		
Work Number Home Number		
If this agent is unable, unwilling, or elsewhere engaged to act as my agent, then I select the following person to act in this role:		
Name:		
Address		
Work Number Home Number		
My agent has full power and right to make health care choices for me:		
Just in regards to the instruction above.		
If my wishes are not expressed above, and my wishes are not otherwise known to my agent, or if my wishes are unknown or unclear, my agent is to make health care choices for me with my best interest in mind, to be determined by my agent after reviewing the benefits, burdens, risks that might result from a a given treatment of course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.		
The authority of my agent is subject to the following conditions and limits:		

My agent has full power and right to:

- 1. Request, receive and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and the right to disclose this information.
- 2. Employ and release my health care providers.
- 3. Approve my admission to or release from any facility (other than psychiatric hospital or unit), nursing home, adult home or other supervised housing or medical care facility.

Circle One:

My agent **HAS NOT** the power and authority to approve my admission to or release from a psychiatric hospital or unit.

Check one:

My agent's powers and rights become active: when my attending physician and a second physician decide that I am unable to make well-versed choices regarding my health care; OR When this document is signed.				
My agent shall not be responsi	ble for costs of care based just on this agreement.			
Date	Signature			
1 0	d or acknowledged signing this advance directive in my ersonal study appears to be a capable person.			
Witness name	Witness signature			
Witness name				